Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ESTROGENS PRIOR AUTHORIZATION FORM *(form effective 7/6/2026)*

Prior authorization guidelines for **Estrogens** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength/concentration:	
Dosage form:	Package size:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. For a non-preferred SYSTEMIC Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred SYSTEMIC Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a non-preferred VAGINAL Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred VAGINAL Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. For a diagnosis of GENDER DYSPHORIA:
☐The prescriber is an endocrinologist or medical provider with experience or training in transgender medicine
☐The drug is prescribed in a manner consistent with current WPATH standards of care

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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